General

Guideline Title

Management of perinatal mood disorders. A national clinical guideline.

Bibliographic Source(s)

Scottish Intercollegiate Guidelines Network (SIGN). Management of perinatal mood disorders. A national clinical guideline. Edinburgh (Scotland): Scottish Intercollegiate Guidelines Network (SIGN); 2012 Mar. 47 p. (SIGN publication; no. 127). [171 references]

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Scottish Intercollegiate Guidelines Network (SIGN). Postnatal depression and puerperal psychosis. A national clinical guideline. Edinburgh (Scotland): Scottish Intercollegiate Guidelines Network (SIGN); 2002 Jun. 28 p. (SIGN publication; no. 60). [171 references]

This guideline was issued in 2012 and will be considered for review in three years. Any amendments to the guideline in the interim period will be noted on the Scottish Intercollegiate Guidelines Network (SIGN) Web site .

Regulatory Alert

FDA Warning/Regulatory Alert

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory and/or warning information has been released.

- May 10, 2016 – Olanzapine : The U.S. Food and Drug Administration (FDA) is warning that the antipsychotic medicine olanzapine can cause a rare but serious skin reaction that can progress to affect other parts of the body. FDA is adding a new warning to the drug labels for all olanzapine-containing products that describes this severe condition known as Drug Reaction with Eosinophilia and Systemic Symptoms (DRESS).

Recommendations

Major Recommendations

Note from the Scottish Intercollegiate Guidelines Network (SIGN) and National Guideline Clearinghouse (NGC): In addition to these evidence-based recommendations, the guideline development group also identifies points of best clinical practice in the full-text guideline document.

The grades of recommendations (A–D) and levels of evidence (1++, 1+, 1-, 2++, 2+, 2-, 3, 4) are defined at the end of the "Major Recommendations" field.

Key Recommendations

The following recommendations were highlighted by the guideline development group as the key clinical recommendations that should be prioritised for implementation. The grade of recommendation relates to the strength of the supporting evidence on which the evidence is based. It does not reflect the clinical importance of the recommendation.

Predicting and Reducing Risk

D - All pregnant women should be asked about personal history of postpartum psychosis, other psychotic disorders (especially bipolar affective disorder and schizophrenia), and severe depressive disorder.

D - All pregnant women should be asked about family history of bipolar disorder or postpartum psychosis.

D - Women at high risk of postnatal major mental illness should have a detailed plan for their late pregnancy and early postnatal psychiatric management, agreed with the woman and shared with maternity services, the community midwifery team, general practitioner (GP), health visitor, mental health services, and the woman herself. With the woman's agreement, a copy of the plan should be kept in her hand held records. The plan should identify what support should be in place and who to contact if problems arise, together with their contact details (including out of hours), and address decisions on medication management in late pregnancy, the immediate postnatal period, and with regard to breastfeeding.

Prevention and Detection

D - Enquiry about depressive symptoms should be made, at minimum, on booking in and postnatally at four to six weeks and three to four months.

Management

B - Cognitive behavioural therapies should be considered for treatment of mild to moderate depression in the postnatal period.

Prescribing Issues

D - All women of childbearing potential who take psychotropic medication should be made aware of the potential effects of medications in pregnancy. The use of reliable contraceptive methods should be discussed.

C - In view of the risk of early teratogenicity and longer term neurobehavioural toxicity, valproate (when used as a mood stabiliser) should not be routinely prescribed to women of childbearing potential.

Predicting and Reducing Risk

Reducing Risk

Antenatal Risk Reduction - Postnatal Depression

B - Psychosocial assessment in the antenatal period for the purposes of identifying risk of postnatal depression should not be routinely offered.

Antenatal Risk Reduction - Postpartum Psychosis

D - All pregnant women should be asked about personal history of postpartum psychosis, other psychotic disorders (especially bipolar affective disorder and schizophrenia), and severe depressive disorder.

D - All pregnant women should be asked about family history of bipolar disorder or postpartum psychosis.

D - The following groups should be considered as high risk for postpartum psychosis:

- Women with a personal history of postpartum psychosis
- Women with a personal history of bipolar affective disorder

Risk is further increased if there is additional family history of postpartum psychosis or bipolar affective disorder.

D - Women at high risk of postnatal major mental illness should have a detailed plan for their late pregnancy and early postnatal psychiatric management, agreed with the woman and shared with maternity services, the community midwifery team, GP, health visitor, mental health services and the woman herself. With the woman's agreement, a copy of the plan should be kept in her hand held records. The plan should identify what support should be in place and who to contact if problems arise, together with their contact details (including out of hours), and address decisions on medication management in late pregnancy, the immediate postnatal period, and with regard to breast feeding.

- Referral for specialist psychiatric assessment should be considered for women with current mood disorder of mild or moderate severity who have a first degree relative with a history of bipolar disorder or postpartum psychosis.
- In the absence of current illness, such a family history indicates a raised, but low, absolute risk of early postpartum serious mental illness. Where family history only is identified, information should be shared between primary care and maternity services, and any evidence of mood disturbance during pregnancy or in the postnatal period should lead to referral to mental health services.

Prevention and Detection

Detection of Antenatal and Postnatal Depression

D - Enquiry about depressive symptoms should be made, at minimum, on booking in and postnatally at four to six weeks and three to four months.

D - For women regarded to be at high risk (those with previous or current depressive disorder), enquiry about depressive symptoms should be made at each contact.

Management

Psychosocial Management

Psychological Therapies

B - Cognitive behavioural therapies should be considered for treatment of mild to moderate depression in the postnatal period.

Mother Infant Interventions

C - Where there is evidence of impairment in the mother-infant relationship, additional interventions, specifically directed at that relationship, should be offered.

Physical Activity

B - Support for structured exercise may be offered as a treatment option for patients with postnatal depression.

Pharmacological Management

Postnatal Depression

Antidepressants

B - Selective serotonin reuptake inhibitors and tricyclic antidepressants may be offered for the treatment of moderate to severe postnatal depression, but with additional considerations regarding the use of antidepressants when breast feeding.

Hormonal Therapies

B - The use of oestrogen therapy in the routine management of patients with postnatal depression is not recommended.

Postpartum Psychosis

D - Postpartum psychosis should be managed in the same way as psychotic disorders at any other time, but with the additional considerations regarding medication use during breast feeding.

Service Design

D - A national managed clinical network for perinatal mental health should be centrally established in Scotland. The network should be managed by a coordinating board of health professionals, health and social care managers, and service users and carers. The network should:

- Establish standards for the provision of regional inpatient specialised mother and baby units, community specialised perinatal teams (or specialised perinatal functions of general adult mental health teams in smaller, or more remote, areas), and maternity liaison services.

- Establish pathways for referral and management of women with, or at risk of, mental illness in pregnancy and the postnatal period.
- Establish standards (in liaison with specialist mental health pharmacists) for the provision of advice and guidance to maternity and primary care services on the use of psychotropic medication in pregnancy and breast feeding.
- Establish competencies and training resources for health professionals caring for pregnant or postnatal women with, or at risk of, mental illness, at levels appropriate to their need.
- Ensure that all pregnant and postnatal women with, or at risk of, mental illness have equitable access to advice and care appropriate to their level of need.

D - Mothers and babies should not routinely be admitted to general psychiatric wards.

Prescribing Issues

Psychotropic Medication Use in the Pre-Pregnancy Period

D - All women of childbearing potential who take psychotropic medication should be made aware of the potential effects of medications in pregnancy. The use of reliable contraceptive methods should be discussed.

Psychotropic Medications in Pregnancy

Antidepressants

C - In view of the association with harms to the fetus and neonate, paroxetine should not generally be initiated as first line therapy in pregnancy. For women already prescribed paroxetine an evaluation of individual risks and benefits should be carried out before a decision is made to continue use or switch to another antidepressant.

Antiepileptic Drugs

C - In view of the risk of early teratogenicity and longer term neurobehavioural toxicity, valproate (when used as a mood stabiliser) should not be routinely prescribed to women of childbearing potential.

C - Valproate should be avoided as a mood stabiliser in pregnancy.

D - All women taking antiepileptic drugs as mood stabilisers should be prescribed a daily dose of 5 mg of folic acid from preconception until at least the end of the first trimester.

Antipsychotics

C - Women taking antipsychotics during pregnancy should be monitored for alterations in fetal growth. Additional monitoring for blood glucose abnormalities is required where olanzapine or clozapine are prescribed.

Hypnotics and Sedatives

C - In women taking benzodiazepines the need for continued use in pregnancy should be reviewed and use should be restricted to short term and low dose where possible. Consideration should be given to tapering the dose prior to childbirth.

Psychotropic Medications during Breast Feeding

Antidepressants

D - Avoid doxepin for treatment of depression in women who are breast feeding. If initiating selective serotonin reuptake inhibitor treatment in breast feeding, then fluoxetine, citalopram, and escitalopram should be avoided if possible.

Lithium

D - In view of the potential risks to the infant of a breastfeeding mother taking lithium, mothers should be encouraged to avoid breast feeding. In mothers taking lithium who have decided to breast feed, close monitoring of the infant, including serum lithium levels, thyroid and renal monitoring should be provided.

Antipsychotics

D - Women who are taking clozapine should not breast feed.

Definitions:

Levels of Evidence

1++: High quality meta-analyses, systematic reviews of randomised controlled trials (RCTs), or RCTs with a very low risk of bias

1+: Well-conducted meta-analyses, systematic reviews, or RCTs with a low risk of bias

1-: Meta-analyses, systematic reviews, or RCTs with a high risk of bias

2++: High quality systematic reviews of case control or cohort studies

High quality case control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal

2+: Well-conducted case control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal2-: Case control or cohort studies with a high risk of confounding or bias and a significant risk that the relationship is not causal

3: Non-analytic studies (e.g., case reports, case series)

4: Expert opinion

Grades of Recommendation

Note: The grade of recommendation relates to the strength of the evidence on which the recommendation is based. It does not reflect the clinical importance of the recommendation.

A: At least one meta-analysis, systematic review, or RCT rated as 1++ and directly applicable to the target population; or

A body of evidence consisting principally of studies rated as 1+, directly applicable to the target population, and demonstrating overall consistency of results

B: A body of evidence including studies rated as 2++, directly applicable to the target population, and demonstrating overall consistency of results; or

Extrapolated evidence from studies rated as 1++ or 1+

C: A body of evidence including studies rated as 2+, directly applicable to the target population and demonstrating overall consistency of results; or

Extrapolated evidence from studies rated as 2++

D: Evidence level 3 or 4; or

Extrapolated evidence from studies rated as 2+

Good Practice Points: Recommended best practice based on the clinical experience of the guideline development group.

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

Perinatal mood disorders, including:

- Postnatal depression
- Puerperal psychosis
- Mood and anxiety disorders in the antenatal period

Note: This guideline defines the antenatal period as that from conception to childbirth, the postnatal period as that from childbirth to the end of the

first postnatal year, and the perinatal period as an overarching term encompassing both. Also, the guideline does not cover the management of other disorders which pose particular risks for women, their pregnancies and infants such as schizophrenia, emotionally unstable personality disorder, eating disorders and substance misuse disorders.

Guideline Category

Counseling

Diagnosis

Management

Prevention

Risk Assessment

Screening

Treatment

Clinical Specialty

Family Practice

Internal Medicine

Nursing

Obstetrics and Gynecology

Pediatrics

Psychiatry

Psychology

Intended Users

Advanced Practice Nurses

Allied Health Personnel

Health Care Providers

Nurses

Patients

Pharmacists

Physician Assistants

Physicians

Psychologists/Non-physician Behavioral Health Clinicians

Public Health Departments

Social Workers

Guideline Objective(s)

- To provide recommendations based on current evidence for best practice in the management of antenatal and postnatal mood and anxiety disorders
- To outline the evidence in relation to the use of psychotropic medications in pregnancy and during breastfeeding
- To assist in the development of local evidence based integrated care pathways and networks

Target Population

Women throughout the perinatal period (from conception to the end of the first postnatal year)

Interventions and Practices Considered

Diagnosis, Screening, and Prevention

1. Family and personal history
2. Psychosocial assessment
3. For women at high risk of postnatal major mental illness:
    - Detailed plan for late pregnancy and early postnatal psychiatric management
    - Referral for specialist psychiatric assessment
    - Enquiry about depressive symptoms at each contact

Management/Treatment

1. Cognitive behavioural therapies
2. Pharmacological management
    - Selective serotonin reuptake inhibitors (SSRIs) and tricyclic antidepressants
    - Therapies considered but not recommended: oestrogen, St. John's Wort and other alternative medicines
3. Counseling for patients taking psychotropic medications
4. Folic acid, particularly for women taking antiepileptic drugs
5. Counseling on risks of mother breastfeeding while taking medications

Major Outcomes Considered

- Predictive value, sensitivity, and specificity of tools for predicting risk for perinatal mood disorders
- Effectiveness of prevention interventions
- Incidence and severity of consequences of perinatal mood disorders
- Effectiveness of treatment interventions
- Risk of fetal and infant adverse effects from maternal drug treatment during pregnancy and lactation

Methodology

Methods Used to Collect/Select the Evidence

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

Systematic Literature Search

The evidence base for this guideline was synthesised in accordance with Scottish Intercollegiate Guidelines Network (SIGN) methodology. A systematic review of the literature was carried out using search strategies devised by a SIGN information specialist. Databases searched include

Medline, Embase, CINAHL, PsycINFO, MIDIRS and the Cochrane Library. For most searches, the date range covered was 1999 to 2010. Internet searches were carried out on various websites including the U.S. National Guideline Clearinghouse, NLH Guidelines Finder, and Guidelines International Network (GIN). The Medline version of the database search strategies for each key question can be found on the SIGN website. The main searches were supplemented by material identified by individual members of the guideline development group.

Literature Search for Patient Issues

At the start of the guideline development process, a SIGN Information Officer conducted a literature search for qualitative and quantitative studies that addressed patient issues of relevance to management of perinatal mood disorders. Databases searched include Medline, Embase, CINAHL and PsycINFO, and the results were summarised and presented to the guideline development group.

Number of Source Documents

Not stated

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Levels of Evidence

1++: High quality meta-analyses, systematic reviews of randomised controlled trials (RCTs), or RCTs with a very low risk of bias

1+: Well-conducted meta-analyses, systematic reviews, or RCTs with a low risk of bias

1-: Meta-analyses, systematic reviews, or RCTs with a high risk of bias

2++: High quality systematic reviews of case control or cohort studies

High quality case control or cohort studies with a very low risk of confounding or bias and a high probability that the relationship is causal

2+: Well-conducted case control or cohort studies with a low risk of confounding or bias and a moderate probability that the relationship is causal2-: Case control or cohort studies with a high risk of confounding or bias and a significant risk that the relationship is not causal

3: Non-analytic studies (e.g., case reports, case series)

4: Expert opinion

Methods Used to Analyze the Evidence

Review of Published Meta-Analyses

Systematic Review with Evidence Tables

Description of the Methods Used to Analyze the Evidence

Once papers have been selected as potential sources of evidence, the methodology used in each study is assessed to ensure its validity. The result of this assessment will affect the level of evidence allocated to the paper, which will in turn influence the grade of recommendation that it supports.

The methodological assessment is based on a number of key questions that focus on those aspects of the study design that research has shown to have a significant influence on the validity of the results reported and conclusions drawn. These key questions differ between study types, and a range of checklists is used to bring a degree of consistency to the assessment process. Scottish Intercollegiate Guidelines Network (SIGN) has based its assessments on the Method for Evaluating Research and Guideline Evidence (MERGE) checklists developed by the New South Wales Department of Health, which have been subjected to wide consultation and evaluation. These checklists were subjected to detailed evaluation and

adaptation to meet SIGN's requirements for a balance between methodological rigour and practicality of use.

The assessment process inevitably involves a degree of subjective judgment. The extent to which a study meets a particular criterion (e.g., an acceptable level of loss to follow up) and, more importantly, the likely impact of this on the reported results from the study will depend on the clinical context. To minimise any potential bias resulting from this, each study must be evaluated independently by at least two group members. Any differences in assessment should then be discussed by the full group. Where differences cannot be resolved, an independent reviewer or an experienced member of SIGN Executive staff will arbitrate to reach an agreed quality assessment.

Evidence Tables

Evidence tables are compiled by SIGN executive staff based on the quality assessments of individual studies provided by guideline development group members. The tables summarise all the validated studies identified from the systematic literature review relating to each key question. These evidence tables form an essential part of the guideline development record and ensure that the basis of the guideline development group's recommendations is transparent.

Additional details can be found in the companion document titled "SIGN 50: A Guideline Developers' Handbook." (Edinburgh [UK]: Scottish Intercollegiate Guidelines Network. [SIGN publication; no. 50]), available from the SIGN Web site .

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

Synthesising the Evidence

Guideline recommendations are graded to differentiate between those based on strong evidence and those based on weak evidence. This judgment is made on the basis of an (objective) assessment of the design and quality of each study and a (perhaps more subjective) judgment on the consistency, clinical relevance, and external validity of the whole body of evidence. The aim is to produce a recommendation that is evidence-based, but which is relevant to the way in which health care is delivered in Scotland and is therefore implementable.

It is important to emphasise that the grading does not relate to the importance of the recommendation, but to the strength of the supporting evidence and, in particular, to the predictive power of the study designs from which that data was obtained. Thus, the grading assigned to a recommendation indicates to users the likelihood that, if that recommendation is implemented, the predicted outcome will be achieved.

Considered Judgment

It is rare for the evidence to show clearly and unambiguously what course of action should be recommended for any given question. Consequently, it is not always clear to those who were not involved in the decision making process how guideline developers were able to arrive at their recommendations, given the evidence they had to base them on. In order to address this problem, SIGN has introduced the concept of considered judgment.

Under the heading of considered judgment, guideline development groups summarise their view of the total body of evidence covered by each evidence table. This summary view is expected to cover the following aspects:

- Quantity, quality, and consistency of evidence
- External validity (generalisability) of study findings
- Directness of application to the target population for the guideline
- Any evidence of potential harms associated with implementation of a recommendation
- Clinical impact (i.e., the extent of the impact on the target patient population, and the resources needed to treat them in accordance with the recommendation)
- Whether, and to what extent, any equality groups may be particularly advantaged or disadvantaged by the recommendations made
- Implementability (i.e., how practical it would be for the National Health Service (NHS) in Scotland to implement the recommendation.)

The groups are finally asked to summarise its view on all of these issues, both the quality of the evidence and its potential impact, before making a graded recommendation. This summary should be succinct, and taken together with its views of the level of evidence represent the first draft of the text that will appear in the guideline immediately before a graded recommendation.

Additional detail about the Scottish Intercollegiate Guidelines SIGN's process for formulating guideline recommendations is provided in Section 6 of the companion document titled "SIGN 50: A Guideline Developers' Handbook." (Edinburgh [UK]: Scottish Intercollegiate Guidelines Network. [SIGN publication; no. 50], available from the SIGN Web site .

Rating Scheme for the Strength of the Recommendations

Grades of Recommendation

Note: The grade of recommendation relates to the strength of the evidence on which the recommendation is based. It does not reflect the clinical importance of the recommendation.

A: At least one meta-analysis, systematic review, or randomised controlled trial (RCT) rated as 1++ and directly applicable to the target population; *or*

A body of evidence consisting principally of studies rated as 1+, directly applicable to the target population, and demonstrating overall consistency of results

B: A body of evidence including studies rated as 2++, directly applicable to the target population, and demonstrating overall consistency of results: *or*

Extrapolated evidence from studies rated as 1++ or 1+

C: A body of evidence including studies rated as 2+, directly applicable to the target population and demonstrating overall consistency of results; *or*

Extrapolated evidence from studies rated as 2++

D: Evidence level 3 or 4; *or*

Extrapolated evidence from studies rated as 2+

Good Practice Points: Recommended best practice based on the clinical experience of the guideline development group

Cost Analysis

The guideline developers reviewed published cost analyses.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

The national open meeting is the main consultative phase of Scottish Intercollegiate Guidelines Network (SIGN) guideline development.

Peer Review

All SIGN guidelines are reviewed in draft form by independent expert referees, who are asked to comment primarily on the comprehensiveness and accuracy of interpretation of the evidence base supporting the recommendations in the guideline. A number of general practitioners (GPs) and other primary care practitioners also provide comments on the guideline from the primary care perspective, concentrating particularly on the clarity of the recommendations and their assessment of the usefulness of the guideline as a working tool for the primary care team. The draft is also sent to at least two lay reviewers in order to obtain comments from the patient's perspective.

It should be noted that all reviewers are invited to comment as individuals, not as representatives of any particular organisation or group. Corporate interests, whether commercial, professional, or societal have an opportunity to make representations at the national meeting stage where they can

send representatives to the meeting or provide comment on the draft produced for that meeting. Peer reviewers are asked to complete a declaration of interests form.

The comments received from peer reviewers and others are carefully tabulated and discussed with the Chair and with the guideline development group. Each point must be addressed and any changes to the guideline as a result noted or, if no change is made, the reasons for this recorded.

As a final quality control check prior to publication, the guideline and the summary of peer reviewers' comments are reviewed by the SIGN Editorial Group for that guideline to ensure that each point has been addressed adequately and that any risk of bias in the guideline development process as a whole has been minimised. Each member of the guideline development group is then asked formally to approve the final guideline for publication.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for each recommendation (see the Major Recommendations field).

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Appropriate management of perinatal mood disorders to decrease the incidence and severity of maternal, fetal, and infant consequences

Potential Harms

Prescribing Issues

Clinicians are understandably cautious about prescribing drugs during pregnancy or when a mother is breast feeding due to the possible risks to the fetus and infant. In early pregnancy the risk of teratogenesis is the main concern. The risks associated with psychotropic drugs in later pregnancy include neonatal toxicity or poor neonatal adaptation following delivery and the possibility of a long term impact on the infant's neurodevelopment. Individual drugs may have other specific risks. During breast feeding many drugs taken by the mother are excreted in milk and ingested by the infant, with consequent concerns about their impact on the infant with regard to both short term toxicity and longer term neurodevelopment. The level of concern about prescribing during pregnancy and lactation is reflected in the Terms of Marketing Authorisation with most psychotropic drugs not being licensed for use in pregnancy and lactation (see the "Qualifying Statements" field). This underlines the need to give very careful consideration to the risks and benefits of prescribing psychotropic medication at this time.

Psychotropic Medications in Pregnancy

See section 6.3 in the original guideline document for a discussion of the evidence examined regarding potential risks associated with psychotropic medication use during pregnancy.

Psychotropic Medications during Breast Feeding

See section 6.4 in the original guideline document for a discussion of the evidence examined regarding potential risks associated with psychotropic medication use during breast feeding.

Qualifying Statements

Qualifying Statements

- This guideline is not intended to be construed or to serve as a standard of care. Standards of care are determined on the basis of all clinical

data available for an individual case and are subject to change as scientific knowledge and technology advance and patterns of care evolve. Adherence to guideline recommendations will not ensure a successful outcome in every case, nor should they be construed as including all proper methods of care or excluding other acceptable methods of care aimed at the same results. The ultimate judgement must be made by the appropriate healthcare professional(s) responsible for clinical decisions regarding a particular clinical procedure or treatment plan. This judgement should only be arrived at following discussion of the options with the patient, covering the diagnostic and treatment choices available. It is, however, advised that significant departures from the national guideline or any local guidelines derived from it should be fully documented in the patient's case notes at the time the relevant decision is taken.

- Recommendations within this guideline are based on the best clinical evidence. Some recommendations may be for medicines prescribed outwith the marketing authorisation (product licence). This is known as 'off label' use. It is not unusual for medicines to be prescribed outwith their product licence and this can be necessary for a variety of reasons.
  Generally the unlicensed use of medicines becomes necessary if the clinical need cannot be met by licensed medicines; such use should be supported by appropriate evidence and experience.

  Medicines may be prescribed outwith their product licence in the following circumstances:

  - For an indication not specified within the marketing authorisation
  - For administration via a different route
  - For administration of a different dose

  "Prescribing medicines outside the recommendations of their marketing authorisation alters (and probably increases) the prescribers' professional responsibility and potential liability. The prescriber should be able to justify and feel competent in using such medicines." Any practitioner following a Scottish Intercollegiate Guidelines Network (SIGN) recommendation and prescribing a licensed medicine outwith the product licence needs to be aware that they are responsible for this decision, and in the event of adverse outcomes, may be required to justify the actions that they have taken.

  Prior to prescribing, the licensing status of a medication should be checked in the most recent version of the British National Formulary (BNF). The summary of product characteristics (SPC) should also be consulted in the electronic medicines compendium (www.medicines.org.uk).

Implementation of the Guideline

Description of Implementation Strategy

Implementation of national clinical guidelines is the responsibility of each National Health Service (NHS) Board and is an essential part of clinical governance. Mechanisms should be in place to review care provided against the guideline recommendations. The reasons for any differences should be assessed and addressed where appropriate. Local arrangements should then be made to implement the national guideline in individual hospitals, units, and practices.

Refer to section 8 of the original guideline for information on resource implications associated with implementing the key clinical recommendations, and advice on audit as a tool to aid implementation.

Implementation Tools

Chart Documentation/Checklists/Forms

Patient Resources

Quick Reference Guides/Physician Guides

Resources

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report

Categories

IOM Care Need

Getting Better

Living with Illness

Staying Healthy

IOM Domain

Effectiveness

Patient-centeredness

Safety

Identifying Information and Availability

Bibliographic Source(s)

Scottish Intercollegiate Guidelines Network (SIGN). Management of perinatal mood disorders. A national clinical guideline. Edinburgh (Scotland): Scottish Intercollegiate Guidelines Network (SIGN); 2012 Mar. 47 p. (SIGN publication; no. 127). [171 references]

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2002 Jun (revised 2012 Mar)

Guideline Developer(s)

Scottish Intercollegiate Guidelines Network - National Government Agency [Non-U.S.]

Source(s) of Funding

Scottish Executive Health Department

Guideline Committee

Guideline Development Group

Composition of Group That Authored the Guideline

Guideline Development Group: Dr Roch Cantwell Consultant Perinatal Psychiatrist, Southern General Hospital, Glasgow (Chair); Ms Juliet

Brown Information Officer, SIGN; Dr Malcolm Cameron Consultant Liaison Psychiatrist, Crosshouse Hospital, Kilmarnock; Dr Patrick Chien Consultant in Obstetrics and Gynaecology, Ninewells Hospital, Dundee; Mrs Elaine Clark Nurse Consultant, Perinatal Mental Health, Southern General Hospital, Glasgow; Ms Fenella Cowey Midwife with Specialist interest in Perinatal Mental Health, Perth Royal Infirmary; Ms Tessa Haring Manager, Postnatal Depression Services, Edinburgh; Mrs Michele Hilton-Boon Information Officer, SIGN; Mrs Joanna Kelly Information Officer, SIGN; Dr Moira Kennedy General Practitioner, The Mill Practice, Dundee; Miss Jennifer Layden Programme Manager, SIGN; Dr Morag Macleod Consultant in Community Psychiatry, Kildean Hospital, Stirling; Dr Gerri Matthews-Smith Senior Lecturer, Napier University, Edinburgh; Ms Susan McConachie Mental Health Nurse Practitioner, Forth Valley Royal Hospital, Larbert; Ms Frances Mitchell Lay Representative, Edinburgh; Miss June Muir Public Health Nurse, Kirklands Hospital, Bothwell; Ms Jane Munro Quality and Audit Development Advisor, Royal College of Midwives, London; Dr Fiona Murray Consultant Perinatal Psychiatrist, St John's Hospital, Livingston; Dr Paul Sclare Consultant Psychiatrist, Cornhill Hospital, Aberdeen; Mrs Lynne Smith Information Officer, SIGN; Ms Margaret Temple Senior Worker, Postnatal Depression Services, Edinburgh; Dr Lorna Thompson Programme Manager, SIGN; Mrs Maree Todd Pharmacist, New Craigs Hospital, Inverness; Ms Amanda Waters Service Manager, East Renfrewshire Primary Care Mental Health Team, Glasgow; Mrs Sherry Wright Senior Pharmacist, Royal Infirmary of Edinburgh

Financial Disclosures/Conflicts of Interest

Declarations of interests were made by all members of the guideline development group. Further details are available from the Scottish Intercollegiate Guidelines Network (SIGN) Executive.

All members of the SIGN Executive make yearly declarations of interest and further details of these are available on request.

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Scottish Intercollegiate Guidelines Network (SIGN). Postnatal depression and puerperal psychosis. A national clinical guideline. Edinburgh (Scotland): Scottish Intercollegiate Guidelines Network (SIGN); 2002 Jun. 28 p. (SIGN publication; no. 60). [171 references]

This guideline was issued in 2012 and will be considered for review in three years. Any amendments to the guideline in the interim period will be noted on the Scottish Intercollegiate Guidelines Network (SIGN) Web site .

Guideline Availability

Electronic copies: Available in Portable Document Format (PDF) from the Scottish Intercollegiate Guidelines Network (SIGN) Web site .

Availability of Companion Documents

The following are available:

- Quick reference guide: Management of perinatal mood disorders), Scottish Intercollegiate Guidelines Network, 2012 Mar. 2 p. Available in Portable Document Format (PDF) from the Scottish Intercollegiate Guidelines Network (SIGN) Web site .
- SIGN 50: A guideline developer's handbook. Edinburgh (Scotland): Scottish Intercollegiate Guidelines Network. (SIGN publication; no. 50). Available from the SIGN Web site .
- Appraising the quality of clinical guidelines. The SIGN guide to the AGREE (Appraisal of Guidelines Research & Evaluation) guideline appraisal instrument. Edinburgh (Scotland): Scottish Intercollegiate Guidelines Network, 2001. Available from the SIGN Web site .
- Podcast. Management of Perinatal Mood Disorders. 2012. Available for download from the SIGN Web site .
- A sample care plan titled Pregnancy and Early Postnatal Care Pathway can be found in Annex 2 of the original guideline document .

Patient Resources

The following is available:

- Mood disorders during pregnancy and after the birth of your baby. A booklet for women and their families. Scottish Intercollegiate Guidelines Network (SIGN), 2012, April. 37 p. Electronic copies: Available in Portable Document Format (PDF) from the SIGN Web site .

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NGC Status

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